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ILMINSTER URBAN DISTRICT COUNCIL

ANNUAL REPORT

OF

THE MEDICAL OFFICER OF HEALTH

For the year ended 31st December, 1956.

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Public Health Inspector

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V.A. Woodhall

To the Chairman and Councillors of the Ilminster Urban District Council,

Mr. Chairman and Gentlemen,

I beg to submit my Annual Report for the year 1956.

It was a healthy year and few cases of infectious disease were notified.

Once again the school dental service was not satisfactory in the area and I have discussed the problem at some length.

The headings under which my Annual Report is produced remain the same each year and this can lead to the danger of it becoming uninteresting through repetition. In order to avoid this, I try to include notes on current problems in the field of preventive medicine and I hope the paragraphs on longevity, the problems of infant welfare and spastics will prove interesting.

I would like to thank the Chairman and Members of the Public Health Committee for the courtesy they have shown me during the year.

I am,

Mr. Chairman and Gentlemen,

Your obedient Servant,

A.M. McCall

Medical Officer of Health

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SECTION A

Statistics and Social Conditions of the Area

Population The Registrar General gives the estimated mid-year population for 1956 as 2,770, a slight increase on 1955. Appendix A, Table 2 gives the general statistical details of the town.

Birth Rate The Birth Rate for Ilminster was 11.9 per thousand live births. This is about the same as the previous year and considerably below the national figure of 15.7. There were no illegitimate births. Details are shown in Appendix A, Table 1

Death Rate The Death Rate for the year was 10.86 per thousand. Less than last year and when the comparability factor (which allows for age and sex difference in the population) is taken into account, it is 10.2 compared with the figure of 11.7 for England and Wales as a whole.

The causes of death are shown in Appendix A, Table 3. Diseases of the heart and circulation were again the greatest killers, having caused 16 deaths out of a total of 30. Cancer came next with a total of 7.

Longevity, which means length of life, is a subject which has always held a great deal of fascination for the man who is impressed by long life in others and usually wants to achieve it himself. There are quite a few of these.

It is fair to say that the age at which one dies depends on how long one succeeds in avoiding death by accident or disease. Since we all die after a maximum of, perhaps, a hundred and ten years, there must be a point beyond which no one can continue to escape the multifarious causes of death which compete for him. The Registrar General recognises a large number of distinct causes of death of which senility is only one and the question arises whether it is possible to die of old age as such. Has an individual a maximum capacity which limits his life so that he must die of a general wearing out of his tissues at an advanced age? The vast majority of human beings die of specific and identifiable failures of structure or function and in a given year very few deaths have to be attributed to senility and other ill defined causes.

Nevertheless, it could be argued that virtually all deaths other than those caused by accident or infection are in fact deaths of old age though not specified as such. These include deaths from degeneration of the heart and arteries and vascular lesions of the nervous system. In addition the age incidence of deaths from cancer allows a case to be made for it as a disease of ageing tissues, as it is essentially due to loss of control over what should be the normal replacement of tissue.

Mans' life seems to be limited to an average of something over 70 years, by which time most people succumb to failure of one system or another. Since a system which fails in one man at 70 may work well in another until something else kills him at 90 or in a third may fail at 45, there is reason to hope that simply by care and forethought man's average lifespan may be prolonged to come a little nearer the apparent maximum of 110.

Every year in England and Wales about half a million people die. If longevity is their aim, then some fall very early by the wayside. Losses are light in the age groups of childhood and youth but from the age of 45 or so onwards casualties are very heavy and very few survive to do better than average in the 80s and 90s.

The first year of life is an immediate problem and danger. Then follows a period of comparative safety. Once 45 is reached men survive far worse than women.

At 75 far more males die than females. The remarkable thing is not that so many women die at ages above 75, but that so many women survive to such advanced ages in this country when their male counterparts die between 45 and 75 in far higher proportion. It is well known that widows far outnumber widowers in England.

It is obvious that in considering the length of life of the ordinary man and the factors affecting it, we must look carefully at the causes of death involved.

Individual tissues have no specific time limit. Most people succumb to a failure, slow or sudden, of a particular system of the body. This may be fatal in itself, or fatal only because of the general senility of the body as a whole. The cardio-vascular system is the one which gives way most often. The general changes which occur with ageing are partly known. The first effect of this is a loss of elasticity in the arterial walls. Most of the deaths due to this are caused by blood clotting in the constricted artery as in coronary thrombosis, where part of the heart muscle is deprived of its blood supply. A large number of deaths are due to the actual rupture of the artery as in cerebral haemorrhage. A non-fatal haemorrhage leads to the familar stroke with varying degree of paralysis. There is a good deal of truth in the cliche that a man is as old as his arteries.

Some obvious changes which occur with ageing are deterioration in the functioning of the organs of special sense. In the eye, accommodation is slowly lost and the nearest clearly visible point receeds - the familar figure of the ageing person holding the paper at arms' length. There is a decreasing range of hearing as age increases, particularly in the higher frequencies. Cerebral development, distinct from development of character and intellect, ceases in youth and the ability to learn decreases slowly, but is masked by the accuracy and wisdom which come with the accumulation of experience. On the whole, normal degeneration of the central nervous system does not affect the length of life though it affects the tempo at which it is lived. Although indigestion is common in older people, the digestive apparatus is very durable and can outlast the rest of the body in most cases. Renal function tends to become less efficient in old age.

Muscle power is usually retained at very nearly the youthful maximum until about 40. It drops slightly then and the drop becomes sharp in the 60s.

The individual variations in the age and extent to which these changes occur are very great indeed, and many 40 year old men are genuinely senile while others in their 70s are well preserved and fairly youthful.

The individual glands have great durability and the system as a whole should easily last a century or more. Few people fail to reach old age because of a failure of the glandular system as such, but it is certainly linked with other systems which breakdown in old age. It may be that some overbalance of the glandular system can lead to a rapid failure of another system.

The respiratory system does not change greatly in old age except in its ability to resist and recover from infection. The lungs, unless subjected over a period of years to silica or coal dust, could outlast most of the rest of the body by many years if it were not for infection. Bronchitis and influenza mainly in old people cause a number of deaths and a failure of the respiratory system to resist infection. So an important factor determining the length of life is the definite lowering of resistance which comes with age and allows the body to be overwhelmed by an attack which it could have survived in youth.

In discussing deaths involving different organs and systems I have omitted deaths caused by cancer. Nearly all such deaths are over 45 years of age and it is one of the biggest stumbling blocks on the road to long life. The otherwise robust digestive organs are heavily involved. Cancer of the lung is not only the commonest cancer is man but one of the main killers of our time. Cancer of the reproductive organs strike women very heavily. Death rates from cancer, both in men and women, have increased in recent years, the greater increase being in males, mainly due to the increase in lung cancer. No special site could be singled out in females. It is important to note that the death rates and incidence rates of cancer in men and women are by no means the same thing. Cancer in men tends to strike in more inaccessible organs and to be less easily and early detected while cancer strikes women chiefly in accessible organs and can be detected sooner. Cancer is an enemy of increasing importance and its grip more than counters the encouraging improvement in the death rate from infectious diseases. The defeat of diseases like diphtheria is a triumph, but it is overshadowed by the increasing menace of cancer.

To summarize I would say that man meets his death not because of any limit to the life of his individual tissues but because the human body is so complex the body's tissues cannot be perfectly and indefinitely maintained in face of the stresses of normal life. Man seems able ideally to live to about 110, but deaths occur at all

ages, mostly in the 60s and 70s. In the normal healthy body changes are continually taking place especially in the cardiovascular system so that hitherto non-fatal stresses and infections become more and more menacing and the eventual failure of one or more systems causes death. The increase in medical knowledge is continuously improving man's ability to ward off infections and recover from them and succeeding generations are living longer and longer. Old people form an ever increasing proportion of the population. But the increasing pace of life brings greater danger in the malignant disturbance of cell replacement called cancer and especially in failure of the circulatory system through the decrease of resilience to stress as age increases. It is against cancer and arterio sclerosis that the battle for longer life must be concentrated.

Infant Mortality No infant died in 1956. There was one still birth.

Maternal Deaths There were no maternal deaths during the year.

Social Conditions There was little change in the social conditions of the town. Some unemployment resulted from the Government credit squeeze and the movement of a section of a large local works to Devon.

SECTION B

General Provision of Health Services in the Area

There were no changes in the Health Services in 1956. It is not the intention of the County Council to provide a clinic building in Ilminster at present. Until we have one it is not easy for the Local Health Authority to increase their Health Services in the town.

Care of Mothers and Young Children

Ante-Natal Clinics No ante-natal clinics are held in Ilminster, but ante-natal examinations are carried out by the general practitioners and the district nurse in the patient's own home. All home confinements are attended by the district nurse under the direction of the private practitioner concerned. Since the closure of the Crewkerne Maternity Unit cases for hospitalization are sent to Taunton.

Domiciliary Midwifery The district nurse continued to attend expectant and nursing mothers in their homes with the private practitioner supervising the case. The practical service of the delivery of the mothers and their after-care follows naturally on the ante-natal work. The mothers approach their time of confinement with the knowledge that they have been well cared for in the preceeding months.

Hospital Confinement Cases requiring admission to hospital, whether on medical or social grounds, were generally admitted to Musgrove Park Hospital, Taunton, which is the nearest midwifery unit.

Infant Welfare Clinic The Infant Welfare Clinic continued to be held weekly and the medical officer attended twice per month. Details of the attendances are shown in Appendix B, Table 1.

Apart from the immunisations and vaccinations he does, the doctor spends a great deal of his time allaying the mothers' fears which often have their origin in the folk lore handed down in families from mother to daughter. Such is the power of the metriarch that it may take many visits to the clinic before the doctor's advice is finally accepted without misgivings.

A strict timetable of ideas was necessary when welfare work started, because infant mortality was so high and the first need being to save life, a life saving rigid discipline was required. Today many modifications of regime are suggested. Nevertheless a certain easy organisation is advised. The exponents of the modern doctrine of self regulation by infants often condemn the timetable in handling the baby. However, a young mother often worried and confused by a situation she has never before encountered is grateful for a simple routine which helps her to plan the management of the baby throughout the day.

As far as is practical breast feeding is advocated. The success of a mother in breast feeding her infants will depend on three simple things. It will depend on the kind and degree of ante-natal care and tuition which the mother has received. It depends upon the psychological attitude of the mother and thirdly it depends upon the composition of the individual mother's breast milk. Advice on all three of these factors are given at the clinic and the amount of breast feeding is to a certain degree a direct guage of the effectiveness of the clinic.

Mothers have become obsessional about their childrens' weight and worry themselves sick if baby is putting on what they imagine is too little and occasionally too much weight. Frequently the problem is a simple one and advice is gratefully received.

Constipation is another constantly recurring problem presented at child welfare clinics. The latin word 'stipare' means to press and so far as derivation goes, constipation means the passage of compressed, that is, hard stools. It is not what it is commonly assumed to be, synonymous with infrequent defaecation, though that is often accompanied by the passage of hard motions. Constipation is the delay in passage of material through the bowel resulting in the formation of hard stools, the passage of which gives discomfort.

The passage of hard stools is not always uncomfortable. There may be a great contrast between the anguish on the face of the mother as she hears the marbles rattle into the pot and the baby's smile of satisfaction.

Constipation has been considered harmful but today it's ill effects are thought

to be only the discomfort of defaecation. No longer is alimentary intoxication believed to be the result from constipation. Yet as a nation we are so pre-occupied about our regular bowel actions that we spend £70 million a year on purgetive pills, tablets and salts. The systems of constipation are probably largely due to fear of constipation and this is partly the result of skilful advertising. 'You may be regular, but you may be a day behind' is a typical example. The fear may also be learnt from mothers who learnt from their mothers: 'no stool, no school' was once a common morning threat.

Constipation often produces symptoms only because the person or parent expects it to do so. At school children are taught how their insides work and how to keep them working well. Earlier than this at the clinic, we try to ensure that, as infants, their bowel training is done with excessive anxiety on the mother's part. Good general advice on infant feeding is a good prophylactic against constipation in infancy.

The world is so full of a number of interesting things that it is a pity that people should spend an excessive amount of time, money and interest on how and what they are excreting.

Health Visiting Mrs. Pitt is the Health Visitor for the area. The primary function of a Health Visitor is to visit the home of the people and I am quite confident that at present this work is being done in a very efficient manner. This is particularly true in respect of the following up of children with defects discovered at school medical inspections. None are overlooked, and if parents co-operate they will derive a maximum benefit from this part of the health service

In addition Mrs. Pitt is the Tuberculosis Health Visitor and in that capacity attends all outpatient sessions at the Chard Chest Hospital. She regularly visits all cases on the T.B. Register and reports on their condition to the Area Chest Physician. Where the home conditions are having an adverse effect on the patient's health, she immediately reports the facts to me and, if necessary, the details are brought to the notice of the Council who have always recognised the importance of good housing in this particular disease.

Immunisation During the year the County Council as local health authority, in co-operation with the local district Council took the opportunity to stress the need for immunisation against diphtheria. The number of primary immunisations carried out during the year was sixteen.

In 1956, following the success of the immunisation programmes in the United States and Scandinavia, the Government launched a campaign for immunisation against Poliomyelitis. It was commenced as a planned field trial and as the supplies of vaccine were very limited indeed only a small percentage of children applying were, in fact, immunised. Only one was chosen from the Ilminster applicants.

Vaccination Eight primary vaccinations were carried out in 1956. This is still not as many as I would like and I think that general practitioners might be able to help in this aspect of preventive medicine by persuading the parents of all infants to accept vaccination.

Home Help Service This Service is organised by the County Council and was available in the town throughout the year. There was slightly less demand than in the previous year.

School Medical Service All schools with the exception of the Girls' Grammar School were inspected by myself during the year and details can be found in Appendix B, Table 2.

Following my inspections of the pupils I always give a report on the hygiene of the school and kitchens and several small improvements resulted from these reports.

Children who have raached the age of 14 years may do part time employment while still attending school. Such work is subject to Byelaws which control the hours and type of work permitted and demand a satisfactory medical examination which I carry out. In this connection I saw four children in 1956.

School Dental Service Ilminster was without a school dental surgeon throughout the year.

Now more than ten years after the war and eight years after the institution of the National Health Service, there are a host of problems for dentists both as individuals and as a responsible group.

Probably the most worrying features of the problem are these:-

1. Britain is only very slowly improving the general standards of oral hygiene

2. There are too few dentists available at present, especially in the school and public dental services

3. There are too few applicants of the right type to the dental schools of Britain

Now, as never before, people are developing a taste for good dental care.

The adult population of this country had just started to realize how poorly it looked after its own and its childrens' teeth when the alteration in payment scales combined with a shortage of dentists to slow down the valuable work which had started. Financial stringency in the public and private purses has rendered more refined conservative and orthodontic work a luxury which is increasingly more hard to support. Though individual dentists produce work of the highest possible standard, generally the National Health Service can only guarantee a bare service of extraction and simple conservative work. The finer and more skilled works which are the technical delight of the good dental surgeon are now under a cloud of mistrust and disapproval - from the patient because of cost and from the Dental Estimates Baords because they view such work as luxurious. In this area the need for a specialist in orthodontics is obvious. The dental practitioner can rarely afford time for work that is inevitably slow and exacting and which may only yield a poor financial reward in proportion to his labour. Yet many children need an orthodontic opinion and treatment and the nearest specialist is either at Bristol or Plymouth.

The shortage of school dentists is even more alarming. The shortage is understandable enough when it is realized that they are the poorest paid of all the profession. One can understand the way in which most newly qualified men go into practice as soon as they can, leaving the financially barren field of childrens' dentistry to enthusiasts who are happily undisturbed by consideration of their bank balances. Thus the majority of dentists go straight into practices where for the rest of their working lives they work hard and continuously for a good salary.

The present dental surgeon has an education which is almost as long as that

of the doctor. The present world wide shortage of dentists leads one to ask whether a simpler form of training, such as the New Zealand dental nurse scheme would not produce a larger number of adequately equipped people to cope with routine work. I think it would be a justifiable step to introduce some modified course of training so that dental auxiliaries can come into being in order to ease the dental surgeon's burden of routine and less skilled work. Such people could help in the provision of an efficient school service provided they worked under the supervision of fully trained dentists.

At present, due to the shortage, the most severely hampered is the school service and a practical way of overcoming the difficulty could be a scheme similar to that whereby hospitals ensure an adequate supply of house officers. A case can be made on grounds of educational desirability and practical expediency for the institution of a pre-registration year for the dentist. He could spend his year either in hospital appointments or in the school dental service.

The General Dental Council is concerned at the poor numbers and quality of the candidates at dental schools. It is certain that maintenance of high professional standards will only be possible if they make it clear that no reduction in professional status can be contemplated. Recruits of the type who are wanted in the profession will not be tempted to join if they see any relaxation of the standards or loss of prestige. The dental surgeon must continue to take his place beside the doctor as a man having a broad medical education as well as the necessary technical skill. If, however, some of the routine work can be passed by the dentist to a new type of technician, I feel that the profession would gain as a whole.

Ophthalmic Service At each medical inspection I examine every child who has any eye defect whatsoever. I check the correction of their glasses and also check up on whether or not they are carrying out the directions issued by the Ophthalmic specialist at the last appointment. If the glasses are in need of repair or the correction does not satisfy me, I refer the child to the County Oculist who holds a weekly clinic especially for school children at Taunton.

Whenever I visit a private school I am struck by the few children who wear glasses as compared with the numbers in a comparable County school. This is not because there is a significant difference between the standard of vision in the two types of school. It is because in the County School regular routine medical inspection is carried out and the defects noticed at an early age. Undoubtedly many visual and indeed other defects remain undetected in school where the children do

not have the benefit of regular medical inspection.

Epileptics Any cases of epilepsy occurring in the area are referred to a Specialist at Taunton who is able to carry out electro-encephalogram and other necessary investigations and then advise on the correct course of treatment. A copy of his report is always available to the School Medical Officer if the patient be of school age. Where it is considered necessary for a schoolchild to attend a special school on account of the disease, it is possible to have them admitted to the Chalfont Colony where the Somerset County Council maintain a certain number of students.

Spastics

During the last few years there has been realization by the public that there should be greater provision for the education and treatment of spastic children. The term is frequently used but few know it's signifiance.

What is a spastic? Most children learn to eat, walk, talk, sit and stand without trouble. Such acts become easy to them because their muscles work together and they have control of them. A child with cerebral palsy (brain palsy) does not have control of all his muscles. As a result he often finds it difficult to do the simple acts of life. He may reach for a cup or pencil; as his hand moves it may miss the mark; he may knock over the cup or drop the pencil.

Another child with cerebral palsy may not be able to walk straight. He seems to get off balance; he may stagger, reel and weave about.

Another child may have trouble with his throat and tongue. If he tries to talk the sounds are often grunts and noises. The muscles of his face may twist and work. Seeing a child making faces and hearing the sounds he makes, give some people a wrong idea. They connect such acts with being feeble minded because some feeble minded children act that way. This may be far from the truth. Some of them are very bright. Some, it is true, are feeble minded but it is not possible to tell just by the way children with cerebral palsy look or act. Mentally the large number of them are about like other children.

The cause is sometimes due to brain damage while the baby is being born. This may be when the mother has a hard and long labour but it is not necessarily the case. It may happen with an easy birth.

Sometimes cerebral palsy may happen after birth and it has followed whooping cough, measles and meningitis.

A large number of spastic children do improve, others do not improve so much, still others not at all. Due to severe mental or physical disability some may have to be cared for in an institution for years.

It is important that all children with cerebral palsy should be under medical care and have opportunities for suitable education just as any other child.

Blind Persons There are twenty-one registered blind persons resident in the area. No cases of ophthalmia neonatorum were notified.

National Assistance Act No statutory action was necessary during the year under this section.

Ambulance Service The Somerset County Council ambulance service covered this area during week days. During the year they have been equipped with radio telephone. This has undoubtedly increased efficiency. During non-working hours and week-ends the Ilminster Ambulance was available to deal with any emergency calls.

SECTION C

Prevalence of and Control over Infectious and Other Diseases

Only a few cases of infectious disease were notified in 1956 which was a very healthy year. A summary of notifications will be found in Appendix C, Table 1.

The Mass X-Ray Unit did not visit Ilminster in 1956.

In December the County Medical Officer announced the arrangements for the routine vaccination of school children against tuberculosis. It was decided to offer B.C.G. vaccination to all children born in 1943, that is, children about 13 years of age. These would then have at least 18 months at school after vaccination and this would allow time to check whether immunity had been conferred and if necessary re-vaccinate. In Somerset the routine B.C.G. vaccination of school children will be carried out by County Staff only and not by general practitioners.

SECTION D

Environmental Health Services

A. Sanitary Circumstances

Climatic Conditions A total of 24.29 inches of rainfall was recorded in 1956. A very dry spring was followed by a wet and disappointing summer. The winter was not severe.

Water Supply The water supply was generally satisfactory, both in quantity and quality and no shortage at all was experienced during the year.

Details of the chemical and bacteriological reports will be found in Appendix D, Table 1, together with other relevant data concerning the distribution of the supply. All piped water in Ilminster is chlorinated before distribution and it will be noted that all the samples of treated water were quite satisfactory. There were no extensions of the piped supply during the year and the only work done was on repair and maintenance.

Drainage and Sewage Disposal There was no change in the method of disposal during the year.

Following a Ministry enquiry in July, the Council's Consulting Engineers are preparing a revised scheme for a new sewage disposal works which, it is hoped, will shortly be submitted to the Ministry. These works are urgently needed to prevent the continued pollution of the River Ile. It is also hoped to re-lay the sewer in West Street and the branch sewers to the High Street houses.

Public Cleansing and Refuse Collection Weekly removal of refuse from each house is carried out by direct labour. In my report last year I referred to the fly nuisance in West Crescent which was thought to be due to the adjacent tip. At that time the Council were actively engaged in trying to find a tip in the Chard Rural District. In June, 1956 the Council commenced tipping at Dowlish Ford in part of the old Chard Canal. Subject to careful control this site should not give rise to nuisance but owing to its high elevation there is always a danger that papers, etc., may scatter over the surrounding countryside and the Council have taken steps to counter-act this danger.

Rodent Destruction The rodent operator continued to carry out routine inspections and treatment when necessary, in the town and no heavy infestations were detected.

Swimming Bath There is only one privately owned swimming bath in the town

and that is at the Ilminster Boys' Grammar School. It is chlorinated by hand and the residual readings are taken 30 minutes after treatment. It is supplied by the town's main water.

Smoke Abatement Little or no trouble was experienced during 1956 due to the industrial smoke. The great majority of smoke pollution in a town of this size is caused by domestic fires, and as the proportion of slow combustion fireplaces increases, it diminishes.

B. Factories Act

During the year inspections of premises under the Factories Act were made and details of this work will be found in Appendix D, Table 2.

C. Housing

Appendix D, Table 3 gives details of the housing situation.

During 1956 the Council mainly considered plans to replace sub-standard property with new houses. In order to emphasize the urgency for this work, the Government have withdrawn the subsidy from council houses with the exception of those which are intended to replace slum property. They also publicised the details about improvement grant facilities under the Housing Acts of 1949 - 1954. In this connection two areas were selected for clearance, one at Winterhay and one in Ditton Street. The former was the subject of an enquiry but there was no objection to the latter and both orders were confirmed by the Ministry. In addition action was taken in respect of unfit houses.

D. Inspection and Supervision of Food

Milk There are three registered distributors and one registered dairy premises in the town. There are three dealers in designated milk and one supplementary license was granted to a distributor whose dairy is outside the area. Sampling was carried out by the County Council staff.

Ice Cream No ice cream is manufactured in Ilminster but eleven premises are registered for the sale of the pre-packed product. Out of 22 samples taken all proved to be satisfactory.

Meat There are three privately owned licensed slaughter houses in the Urban District and the meat there was inspected by the Public Health Inspector. It is regretted that the details of these inspections are not available as the Inspector has left the Council's service.

Licensed Premises. During the last twelve months the Public Health Inspector and I have inspected all licensed premises in the town. Following the first

inspection a list of defects and requirements were sent to the Brewers concerned and a copy of this letter was also forwarded to the Clerk to the Licensing Magistrates. A second visit was carried out at the end of the year ready for the next licensing session early in 1957 and I am pleased to be able to report that the majority of my recommendations received attention. The outstanding points will be followed up.

Clean Food Campaign In 1956 the Public Health Committee concentrated their efforts on the improvement of the hygiene of all food premises in the town. In order to ensure that the same standard of hygiene obtained inIlminster as in the neighbouring districts we sent representatives to a combined meeting in which the new Food Hygiene Regulations were discussed. As a result the Public Health Officers of all districts in this part of Somerset interpret the Regulations in the same way and thus avoid anomalies. The Council also sent a precis of the Regulations to every food trader in Ilminster so that there should be no possibility of their being unaware of their obligations. Routine inspection of all food premises was proceeding at the end of the year.

APPENDIX A, TABLE 1.

Registrar General's Estimate of population mid 1956	2,770
Area	531 acres
Number of inhabited houses at the end of 1956 according to the Rate Book	970
Rateable Value	£31,031
Sum represented by a penny rate	£122

APPENDIX A, TABLE 2.

BIRTH RATE — Comparability Factor 1.00

		M.	F.
Live Births	Total	13	20
	Legitimate	11	20
	Illegitimate	2	-
Still Births	Total	1	-
	Legitimate	1	-
	Illegitimate	-	-
Deaths of Infants under 1 year	Total	-	-
	Legitimate	-	-
	Illegitimate	-	-
Deaths of Infants under 4 weeks	Total	-	-
	Legitimate	-	-
	Illegitimate	-	-

APPENDIX A, TABLE 3.

DEATH RATE — Comparability Factor 0.94

Table of Deaths		Total	M.	F.
		30	14	16
Causes of Deaths				
Heart:	Coronary Disease	3	3	-
	Other heart disease	8	4	4
Circulation	Vascular lesions of nervous system	5	2	3
	Other circulatory diseases	3	1	2
Cancer of:	Stomach	2	1	1
	Lung	1	1	-
	Breast	2	-	2
	Other sites	2	1	1
Diabetes		1	-	1
Other ill-defined diseases		2	-	2
Suicide		1	1	-

APPENDIX B, TABLE 1.

Ilminster Child Welfare Centre,

Statistics for the twelve months ended 31st December, 1956.

1. Number of children who first attended during the year and who at their first attendance were:-

UNDER ONE YEAR OF AGE	63

2. Number of children who attended during the year and who were born in:-

(a) 1956	38
(b) 1955	31
(c) 1954-51	249

3. Total attendances during the year made by children who at the date of attendance were:-

(a) UNDER ONE YEAR OF AGE	321
(b) OVER ONE BUT UNDER TWO YEARS OF AGE	228
(c) OVER TWO BUT UNDER FIVE YEARS OF AGE	331

4. Number of individual mothers who attended during the year	114
5. (a) TOTAL NUMBER OF SESSIONS HELD:-	
(i) With Medical Officer	24
(ii) Other Sessions	27
(b) NUMBER OF CHILDREN EXAMINED BY DOCTOR	80
(c) TOTAL NUMBER OF MEDICAL CONSULTATIONS	221

APPENDIX B, TABLE 2.

Name of School	No. on Roll	No. Inspected	Date of Inspection	Children having milk	Children having dinner	No. Immunised
Ilminster Junior Boys'	108	34	1. 2.56.	83.33%	60.19%	-
Ilminster Boys'	151	38	20. 7.56.	59.60%	48.34%	-
Grammar	171	58	5.12.56.	70.17%	53.80%	-
Ilminster Junior Girls'	116	46	3. 2.56.	98.28%	62.10%	-
Ilminster Infants'	106	65	15/16. 3.56.	88.68%	56.60%	-
Ilminster Secondary	298	92	20/21/22.6.56.	33.88%	71.47%	-
Modern	344	103	20/21/23.11.56.	29.07%	62.5%	-

APPENDIX C, TABLE 1.

Infectious and Other Notifiable Diseases

Measles	13
Scarlet Fever	7
Dysentery	1
Pneumonia	1

Analysis of Cases Notified

	Under 1 yr.	1-2	2-3	3-4	4-5	5-10	10-15	15-20	20-35	35-45	45-65	65+
Measles			1	3	2	7						
Scarlet Fever				1	1	4	1					
Dysentery						1						
Pneumonia						1				1		

TUBERCULOSIS

	New Cases				Deaths			
	Respiratory		Non-Respiratory		Respiratory		Non-Respiratory	
Age Group	M	F	M	F	M	F	M	F
- 1								
1 - 5								
5 - 15								
15 - 25								
25 - 35	1							
35 - 45	1							
45 - 55								
55 - 65								
65 +								
Totals	2							

APPENDIX D, TABLE 1.

Water Supply

Piped Supplies - results of samples taken for Analysis:

Raw Water				Treated after going into Supply			
Bacteriological		Chemical		Bacteriological		Chemical	
Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory
-	-	-	-	8	-	-	1

Water Supplies from Public Mains:

Direct to Houses		By Means of Standpipes	
No. of Dwelling Houses	Population	No. of Dwelling Houses	Population
733	2,110	230	640

APPENDIX D, TABLE 2.

Factories Act, 1937.

Inspections for the purpose of provisions as to Health (including inspections made by the Public Health Officer).

Premises	Number on Register	Inspections	Written Notices	Occupiers Prosecuted
Factories in which Sections 1, 2, 3, 4 and 6, are to be enforced by Local Authorities	3	6		
Factories not included in (i) in which Section 7 is enforced by the Local Authority	23	40		
Totals	26	46		

Cases in which defects were found ... ... Nil

Cases in which defects found were remedied .. .. Nil

Outworkers

No. of outworkers in August List required by Section 10 23

APPENDIX D, TABLE 3.

Housing.

Total number of permanent dwellings in District	973
Total number of permanent dwellings owned by Local Authority	203

	1955	1956
Estimated number of houses unfit for human habitation (As per Ministry Circular 55/54)	80	76
Action taken during year:-		
1. Number of houses in Clearance Areas for which ..	-	4
(a) Clearance Orders have been made... ...	-	-
(b) Compulsory Purchase Order made	-	-
(c) Purchased by Agreement	-	-
Totals	80	80

2. No. of houses included in Clearance Area.. ... still to be made	5
3. No. of houses in Clearance Areas which have been patched for temporary accommodation under Section 2 of the Housing Repairs and Rents Act, 1954	-
4. No. of houses demolished under Section 25 of the Housing Act, 1936.	-
5. No. of houses demolished under Section 11 of the Housing Act, 1936.	-
6. No. of temporary dwellings (huts, etc.) demolished	-
7. No. of houses declared unfit under Section 9 of the Housing Repairs and Rents Act, 1954...	-
8. No. of houses closed as a result of an undertaking given by the owners or following the issue of Closing Orders	3
9. No, of unfit houses occupied under licence ...	-

	Houses erected during year		Houses in course of erection		Gained from conversion of large houses or buildings into flats or dwellings	Lost from conversion of two or more houses to one
	For Slum Clearance	For Other Purposes	For Slum Clearance	For Other Purposes		
Local Authority	-	6	7	5	-	-
Private Enterprise	-	-	-	2	-	-

No. of Post-War Houses erected from 1st April, 1945 to 31st December, 1956		Housing Programme for 1957	
By Local Authority	By Private Enterprise	For Slum Clearance	For Other Purposes
154	45	7	9

(a) No. of temporary housing units occupied -	(i) Prefabs	50
	(ii) Huts, etc.	-
(b) No. of houses found overcrowded		-
(c) No. of houses made fit during year		4

Houses required:-

(i) To replace houses scheduled for demolition	130
(ii) To abate overcrowding	
(iii) For other purposes	
Total number of applications for Council Houses at the end of the year	92
Total number of Council Houses sold during year	Nil

Improvement Grants made under the Housing Act, 1949 - 54.

No. of applications and houses dealt with by Local Authority:-

	(1) Received		(2) Approved		(3) Rejected	
	Applications	No. of dwellings	Applications	No. of dwellings	Applications	No. of dwellings
31.7.49 - 31.12.55) During Year)	10	10	9	9	1	1

NOTE Number of applications approved in respect of owner/occupiers	7
Average cost per dwelling approved	£162

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